		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037044

Facility Name: Lincoln Square

Address: 202 South Main (Number) Jonesboro (City) 62952 (Zip Code)

County: Union

Telephone Number: (618) 833-2063 **Fax #** (618) 833-4993

IDPA ID Number: 37-1272697001

Date of Initial License for Current Owners: 01-06-88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Richard Stroh **Telephone Number:** (618) 833-5070 ext. 11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard Stroh
(Title) Asst. Comptroller

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 15 Bed / 5475 Bed Days

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,475			5,475	13
14	TOTALS	5,475			5,475	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 100.00%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/06/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	22,957	1,367	1,154	25,478		25,478		25,478			1
2	Food Purchase		37,482		37,482		37,482		37,482			2
3	Housekeeping	12,680	4,322	720	17,722		17,722	92	17,814			3
4	Laundry	552	538		1,090		1,090		1,090			4
5	Heat and Other Utilities			10,596	10,596		10,596		10,596			5
6	Maintenance		115	3,981	4,096		4,096	4,258	8,354			6
7	Other (specify):*											7
8	**TOTAL General Services**	36,189	43,824	16,451	96,464		96,464	4,350	100,814			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	120,691	3,744	10,551	134,986		134,986	1,212	136,198			10
10a	Therapy			1,771	1,771		1,771		1,771			10a
11	Activities		810	1,005	1,815		1,815		1,815			11
12	Social Services	17,650	(80)	963	18,533		18,533		18,533			12
13	Nurse Aide Training	318			318		318		318			13
14	Program Transportation			1,491	1,491		1,491		1,491			14
15	Other (specify):* **Day Training Expense**			137,986	137,986		137,986	(137,986)				15
16	**TOTAL Health Care and Programs**	138,659	4,474	153,767	296,900		296,900	(136,774)	160,126			16
	C. General Administration											
17	Administrative			1,000	1,000		1,000	5,481	6,481			17
18	Directors Fees											18
19	Professional Services			23,690	23,690		23,690	(22,830)	860			19
20	Dues, Fees, Subscriptions & Promotions			1,875	1,875		1,875	(261)	1,614			20
21	Clerical & General Office Expenses		2,297	5,039	7,336		7,336	7,679	15,015			21
22	Employee Benefits & Payroll Taxes			25,819	25,819		25,819	3,896	29,715			22
23	Inservice Training & Education			2,110	2,110		2,110	30	2,140			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,555	3,555		3,555	334	3,889			26
27	Other (specify):* **Tax Penalty**			358	358		358		358			27
28	**TOTAL General Administration**		2,297	63,446	65,743		65,743	(5,671)	60,072			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	174,848	50,595	233,664	459,107		459,107	(138,095)	321,012			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lincoln Square #0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation				6,282		6,282	11,552	17,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			676	676		676	(370)	306			32
33	Real Estate Taxes			5,356	5,356		5,356	116	5,472			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(35,458)	542			34
35	Rent-Equipment & Vehicles			90	90		90		90			35
36	Other (specify):* Inc. Tax & Bad Debt			4,156	4,156		4,156	(4,156)				36
37	**TOTAL Ownership**			46,278	52,560		52,560	(28,316)	24,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,123		5,123		5,123		5,123			41
42	Provider Participation Fee			28,956	28,956		28,956		28,956			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		5,123	28,956	34,079		34,079		34,079			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	174,848	55,718	308,898	545,746		545,746	(166,411)	379,335			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (137,986)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,804	30		9
10	Interest and Other Investment Income	(370)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(297)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,707)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,449)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Diapers	(9)	12		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,014)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(26,406)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (26,406)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (166,420)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lincoln Square

ID# 0037044

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	92	0	0	0	0	0	0	0	0	0	92	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	586	3,672	0	0	0	0	0	0	0	0	4,258	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	678	3,672	0	0	0	0	0	0	0	0	4,350	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	1,212	0	0	0	0	0	0	0	0	1,212	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(137,986)	0	0	0	0	0	0	0	0	0	0	(137,986)	15
16	**TOTAL Health Care and Programs**	(137,986)	0	1,212	0	0	0	0	0	0	0	0	(136,774)	16
	C. General Administration													
17	Administrative	0	0	5,481	0	0	0	0	0	0	0	0	5,481	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	302	(23,132)	0	0	0	0	0	0	0	0	(22,830)	19
20	Fees, Subscriptions & Promotions	(297)	36	0	0	0	0	0	0	0	0	0	(261)	20
21	Clerical & General Office Expenses	0	1,159	6,520	0	0	0	0	0	0	0	0	7,679	21
22	Employee Benefits & Payroll Taxes	0	3,896	0	0	0	0	0	0	0	0	0	3,896	22
23	Inservice Training & Education	0	30	0	0	0	0	0	0	0	0	0	30	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	334	0	0	0	0	0	0	0	0	0	334	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(297)	5,757	(11,131)	0	0	0	0	0	0	0	0	(5,671)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(138,283)	6,435	(6,247)	0	0	0	0	0	0	0	0	(138,095)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lincoln Square **#** 0037044 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,804	1,018	7,730	0	0	0	0	0	0	0	0	11,552	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(370)	0	0	0	0	0	0	0	0	0	0	(370)	32
33	Real Estate Taxes	0	116	0	0	0	0	0	0	0	0	0	116	33
34	Rent-Facility & Grounds	0	542	(36,000)	0	0	0	0	0	0	0	0	(35,458)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(4,156)	0	0	0	0	0	0	0	0	0	0	(4,156)	36
37	**TOTAL Ownership**	(1,722)	1,676	(28,270)	0	0	0	0	0	0	0	0	(28,316)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,005)	8,111	(34,517)	0	0	0	0	0	0	0	0	(166,411)	45

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dianna Alley	50	Mulberry Manor	Anna	kel-Tech Mgmt Co.	Anna	Accounting Serv.
Jacob Alley	50	Holly Hill	Anna	JR Centre	Anna	Day Training
		Glen Brook	Vienna	ILS 1-3	Anna	CILA
		Pilot House	Cairo	ILS 4	Metropolis	CILA
		Krypton	Metropolis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	HOUSEKEEPING	$	kel-Tech Management Co.	25.00%	$ 92	$ 92	1
2	V	6	MAINTENAMCE		kel-Tech Management Co.	25.00%	586	586	2
3	V	19	PROFESSIONAL SERVICES		kel-Tech Management Co.	25.00%	302	302	3
4	V	20	DEUS, FEES & SUBSCRIPTION		kel-Tech Management Co.	25.00%	36	36	4
5	V	21	CLERICAL & GEN OFFICE		kel-Tech Management Co.	25.00%	1,159	1,159	5
6	V	22	EMPLOYEE BENEFITS		kel-Tech Management Co.	25.00%	3,896	3,896	6
7	V	23	TRAINING		kel-Tech Management Co.	25.00%	30	30	7
8	V	26	INSURANCE		kel-Tech Management Co.	25.00%	334	334	8
9	V	30	DEPRECIATION		kel-Tech Management Co.	25.00%	1,018	1,018	9
10	V	33	R/E TAXES		kel-Tech Management Co.	25.00%	116	116	10
11	V	34	RENT GROUNDS		kel-Tech Management Co.	25.00%	542	542	11
12	V								12
13	V								13
14	Total			$			$ 8,111	$ * 8,111	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING WAGES	$	kel-Tech Management Co.	25.00%	$ 1,212	$ 1,212	15
16	V	17	ADMINIATRATIVE WAGES		kel-Tech Management Co.	25.00%	5,481	5,481	16
17	V	21	CLERICAL WAGES		kel-Tech Management Co.	25.00%	6,520	6,520	17
18	V	6	MAINTENANCE WAGES		kel-Tech Management Co.	25.00%	3,672	3,672	18
19	V	19	PROFESSIONAL SERVICES	23,132	kel-Tech Management Co.			(23,132)	19
20	V	34	BUILDING LEASE	36,000	J & J PARTNERS			(36,000)	20
21	V	30	DEPRECIATION		J & J PARTNERS		7,730	7,730	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 59,132			$ 24,615	$ * (34,517)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Diana Alley	DON/ Owner		50.00	48,006	8	20.00	Nuraing	$ 12,945	10-1	1
2	Jacob Alley	Owner		50.00							2
3											3
4											4
5											5
6	kel-Tech Mgmt Co. Allocation Wages										6
7	Diana Alley							Nursing	1,212		7
8	Jacob Alley							Maintenance	3,409		8
9	James A. Keller							Administraive	4,559		9
10	Don Pippins							Administraive	923		10
11											11
12		Schedule of Owner Compensation all facilities Pg 24.									12
13								TOTAL	$ 23,048		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E. Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618) 833-5070
Fax Number: (618) 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	307,254	11	$ 1,220	$	23,132	$ 92	1
2	6	UTILITIES	Mgmt Fee Contribution	307,254	11	2,992		23,132	225	2
3	6	MAINT.-VEHICLES	Mgmt Fee Contribution	307,254	11	207		23,132	16	3
4	6	MAINT.SUPPLIES	Mgmt Fee Contribution	307,254	11	232		23,132	17	4
5	6	GROUNDS MAINT.	Mgmt Fee Contribution	307,254	11	345		23,132	26	5
6	6	REPAIRS-VEHICLES	Mgmt Fee Contribution	307,254	11	551		23,132	42	6
7	6	REPAIRS-BUILDINGS	Mgmt Fee Contribution	307,254	11	77		23,132	6	7
8	6	REPAIRS	Mgmt Fee Contribution	307,254	11	849		23,132	64	8
9	6	TRANSPORTATION	Mgmt Fee Contribution	307,254	11	2,525		23,132	190	9
10	19	LEGAL & ACCOUNTING	Mgmt Fee Contribution	307,254	11	4,005		23,132	302	10
11	20	DUES,FEES,SUBSCRIPTIONS	Mgmt Fee Contribution	307,254	11	481		23,132	36	11
12	21	G & A SUPPLIES	Mgmt Fee Contribution	307,254	11	5,773		23,132	435	12
13	21	POSTAGE	Mgmt Fee Contribution	307,254	11	2,732		23,132	206	13
14	21	SOFTWARE EXP.	Mgmt Fee Contribution	307,254	11	486		23,132	37	14
15	21	LEASE-EQUIPMENT	Mgmt Fee Contribution	307,254	11	1,158		23,132	87	15
16	21	G & A MISC.	Mgmt Fee Contribution	307,254	11	492		23,132	37	16
17	21	TELEPHONE	Mgmt Fee Contribution	307,254	11	2,964		23,132	223	17
18	21	TELEPHONE CELL	Mgmt Fee Contribution	307,254	11	1,228		23,132	92	18
19	21	PRINTING	Mgmt Fee Contribution	307,254	11	104		23,132	8	19
20	21	COPIER EXPENSE	Mgmt Fee Contribution	307,254	11	465		23,132	35	20
21	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	307,254	11	18,005		23,132	1,356	21
22	22	INS.-EMPLOYEE GROUP	Mgmt Fee Contribution	307,254	11	31,539		23,132	2,374	22
23	22	INSURANCE-W/C	Mgmt Fee Contribution	307,254	11	2,207		23,132	166	23
24	23	STAFF TRAINING	Mgmt Fee Contribution	307,254	11	405		23,132	30	24
25	TOTALS					$ 81,042	$		$ 6,102	25

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E. Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618) 883-5070
Fax Number: (618) 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE-VEHICLES	Mgmt Fee Contribution	307,254	11	$ 1,241	$	23,132	$ 93	1
2	26	INSURANCE-BLDG. & LIAB.	Mgmt Fee Contribution	307,254	11	3,198		23,132	241	2
3	30	DEPRECIATION	Mgmt Fee Contribution	307,254	11	13,528		23,132	1,018	3
4	33	REAL ESTATE TAXES	Mgmt Fee Contribution	307,254	11	1,538		23,132	116	4
5	34	LEASE-Building	Mgmt Fee Contribution	307,254	11	7,200		23,132	542	5
6	10	NURSING WAGES	Mgmt Fee Contribution	307,254	11	16,098	16,098	23,132	1,212	6
7	17	ADMINISTRATIVE WAGES	Mgmt Fee Contribution	307,254	11	72,808	72,808	23,132	5,481	7
8	21	CLERICAL WAGES	Mgmt Fee Contribution	307,254	11	86,601	86,601	23,132	6,520	8
9	6	MAINTENANCE WAGES	Mgmt Fee Contribution	307,254	11	48,767	48,767	23,132	3,671	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 250,979	$ 224,274		$ 18,894	25

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ford Credit		X	Vehicle Purchase	$797.00	9/23/00	$ 26,232	$ 7,015	9/2003	5.9000	$ 676	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$797.00		$ 26,232	$ 7,015			$ 676	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 26,232	$ 7,015			$ 676	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	5,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	5,156	2
3. Under or (over) accrual (line 2 minus line 1).	$	56	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	5,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	5,356	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	4,771	8
	1998	4,724	9
	1999	4,828	10
	2000	5,029	11
	2001	5,156	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lincoln Square COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037044

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 ext. 11 FAX #: (618) 833-4993

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-00-07-353	Lot 69 Grammer's Donation	$ 5,156.18	$ 5,156.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,156.18	$ 5,156.18

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,200 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Healthcare	8,000	1987	$ 10,000	1
2					2
3	TOTALS	8,000		$ 10,000	3

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1997	4,056		7	271	271	4,056	9
10	Carpeting Livingroom			1998	571		7	57	57	571	10
11	Carpeting			2001	3,640		7	520	520	3,640	11
12	Tile Floor			2002	3,922	1,314	15	196	(1,118)	1,314	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,189	$ 1,314		$ 1,044	$ (270)	$ 9,581	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,745	$ 335	$ 349	$ 14	5	$ 1,242	71
72	Current Year Purchases	3,076	3,076	440	(2,636)	7	3,076	72
73	Fully Depreciated Assets	54,974		2,007	2,007	7	54,976	73
74								74
75	TOTALS	$ 59,795	$ 3,411	$ 2,796	$ (615)		$ 59,294	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Van Ford 1994	1994	$ 21,203	$	$	$	5	$ 21,203	76
77	Healthcare	vVan Ford 2001	2001	26,232	1,557	5,246	3,689	5	23,896	77
78										78
79										79
80	TOTALS			$ 47,435	$ 1,557	$ 5,246	$ 3,689		$ 45,099	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 129,419	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,282	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,086	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,804	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 113,974	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 90 Description: Water Cooler $90
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 44

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 86

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		140		140
4	Clinical Wages	(b)		178		178
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 318	$	$ 318
10	SUM OF line 9, col. 1 and 2	(e)	$ 318			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10-3	visits		4	140		4	140	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	4	$ 140	$	4	$ 140	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 37,094	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	109,398		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	30,315		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 176,807	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	119,420		16
17	Accumulated Depreciation (book methods)	(113,969)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,896		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,896)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,451	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 182,258	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,120	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	5,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,449		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 18,028	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,015		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,015	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,043	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 157,215	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 182,258	$	48

***(See instructions.)**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 156,564	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 156,564	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	95,760	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(95,109)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 651	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 157,215	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 501,177	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 501,177	3
	B. Ancillary Revenue		
4	Day Care	137,986	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 137,986	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	486	11
12	Gift and Coffee Shop	1,483	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,969	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	306	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 306	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Handling Fee & Misc. Income	68	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 68	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 641,506	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	96,724	31
32	Health Care	296,625	32
33	General Administration	65,758	33
	B. Capital Expense		
34	Ownership	52,560	34
	C. Ancillary Expense		
35	Special Cost Centers	5,123	35
36	Provider Participation Fee	28,956	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 545,746	40
41	**Income before Income Taxes (line 30 minus line 40)****	95,760	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 95,760	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	400	400	$ 12,945	$ 32.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,940	2,012	17,650	8.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,038	2,086	22,957	11.01	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,594	1,667	13,232	7.94	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,040	2,080	29,963	14.41	29
30	Habilitation Aides (DD Homes)	9,635	9,811	78,101	7.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,647	18,056	$ 174,848 *	$ 9.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,154	1-3	35
36	Medical Director	12	3,600	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	59	590	10-3	38
39	Pharmacist Consultant	12	360	10-3	39
40	Physical Therapy Consultant	2	138	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	1,771	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	23	924	12-3	45
46	Other(specify) Psychologist	85	3,828	10-3	46
47	Dental Consultant	12	1,200	10-3	47
48	Administrator Consultant	12	1,000	17-3	48
49	TOTAL (lines 35 - 48)	274	$ 14,565		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Administrative Consultant	$ 1,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
kel-Tech Mgmt Co.	Mgmt Services	$ 23,132
Barnett & Levine	Accting Services	475
FMRG	Legal Services	83
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 23,690

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,268
Unemployment Compensation Insurance	2,333
FICA Taxes	13,209
Employee Health Insurance	6,009
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
kel-Tech Mgmt Allocation	3,896
TOTAL (agree to Schedule V, line 22, col.8)	$ 29,715

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 2)	24
Assoc. Dues	873
Subscriptions	401
PAC Dues	72
Contributions	225
Corp. Ann. Report	80
kel-Tech Mgmt Allocation	36
Less: Public Relations Expense	(297)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,614

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lincoln Square # 0037044 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Assoc. $873**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9** Line **12**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Lincoln Square #0032469 01/06/88

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **28,956**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Audit is not required of this facility.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
Owners Compensation
Jan 1, 2002 - Dec 31, 2002

	Totals/Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook
Don Pippins	$108,359.00	$9,500.00	$12,000.00	$25,395.00			$6,000.00		$12,264.00	$43,200.00	
Denise Pippins	$113,480.00	36,000.00	21,600.00	55,880.00							
Diana Alley	$84,849.00	12,000.00	24,000.00	7,800.00	12,006.00			12,945.00	16,098.00		
Jo Ann Keller	$120,153.00			7,000.00	88,557.00	24,596.00					
James K. Keller	$22,657.00			7,000.00	15,657.00						
Jacob Alley	$45,268.00								45,268.00		
James A. Keller	$89,644.00		18,000.00						60,544.00		11,100.00
	$584,410.00	$57,500.00	$75,600.00	$103,075.00	$116,220.00	$24,596.00	$6,000.00	$12,945.00	$134,174.00	$43,200.00	$11,100.00

Lincoln Square, Inc.
Depreciation Reconciliation
2002

Sch 5, Line 30, Column 8		Sch 11, Line 84, Column 2	
Lincoln Square Tax Depreciation	$ 6,282.00	Lincoln Square Tax Depreciation	$ 6,282.00
Adjustment to Straight Line Deprec.	2,804.00	Adjustment to Straight Line Deprec.	2,804.00
J & J Partners Depreciation	7,730.00		
kel-Tech Mgmt Allocation	1,018.00		-
	$ 17,834.00		$ 9,086.00

Lincoln Square, Inc.
Depreciation of Sch. 17, Line 41 to Tax Return
2002

Sch. 17, Line 41	$ 95,760.00
Contributions	225.00
Penalties	358.00
Interest Income to Schedule K	(306.00)
Section 179 Expenses	3,076.00
Rounding	1.00
Tax Return	$ 99,114.00